Alaska Foot & Ankle Specialists

YOU:

Name: Cary King
Mailing Address: POB 100246
City/State/Zip: Anchorage, Alaska 99510
Email: cking@redcarrotdesign.com
Employer: Red Carrot Design
Occupation: designer

Birthdate: 09/28/64
Phone #s: (Indicate the best way to reach you)
☑ Cell (907) 240-7744
☑ Home (907) 770-2810
☑ Work (907) 770-2810
Soc Sec #: 574-60-3178

Martial Status: ☐ Single ☑ Married ☐ Separated ☐ Divorced ☐ Widowed

☑ SPOUSE / GUARDIAN: and/or ☐ EMERGENCY CONTACT:

Name: Jill King
Street Address: PO Box 100246
City/State/Zip: Anchorage, Alaska 99510
Email: jking@redcarrotdesign.com
Employer: Red Carrot Design
Occupation: designer

Relationship to Patient: Spouse
Phone #s: (Indicate the best way to reach you)
☑ Cell (907) 441-7791
☑ Home (907) 770-2810
☑ Work (907) 770-2810
Soc Sec #: 574-54-5210

PRIMARY INSURANCE:

Insurance Company: Self Pay
Policy Holder: ☑ Self ☑ Spouse ☑ Parent
Policy Holder Name: jajaj

Subscriber ID:
Group ID:
Date of Birth: 09/28/64

SECONDARY INSURANCE:

Insurance Company: jljlkjlk
Policy Holder: ☑ Self ☑ Spouse ☑ Parent
Policy Holder Name: lkjlkjlkj

Subscriber ID: lkjlkjlk
Group ID: jlkjlkjl
Date of Birth: 09/28/64

OTHER:

List names of people who are authorized to share your medical information:
Name: Jill King — Relationship to Patient: Spouse
Name: Alexine — Relationship to Patient: Mother

Preferred Pharmacy: Walgreens

What type of message would you like us to leave?
(Circle one) Detailed or General

Primary Care / Family Physician: Dr Scott
Who Referred You? None

By signing below, I authorize the Practice to release any information acquired in the course of my treatment necessary to process insurance claims and authorize payment directly to the Physician. I understand that I am responsible for any amount not covered by insurance. Please understand insurance is billed as a courtesy.
Protected health information may be disclosed to another covered entity for select health care operations, such as; payment activities, treatment quality assessment activities and other purposes. I have been offered a copy of the Notice of Privacy Policy. I understand the organized health care arrangement has the right to change this notice at any time and I may obtain a current copy by contacting this office. **Also, I understand that I am ultimately responsible for all charges, regardless of insurance coverage.**

Signature: _____ Date: _____

Please be sure to let us know of any updates to this information!

Patient Name: (Last, First, MI) _____ Date Of Birth: _____ Age: ____

Referring Physician: (If applicable) _____

What is the chief complaint for which you came to be treated? (Please include foot, ankle, knee, thigh, and hip complaints): ____

_____

Cigarette/Tobacco use? ☐ Yes ☐ No Number of years _____ Is there a family history of Diabetes? ☐ Yes ☐ No

Do you drink alcohol? ☐ none ☐ daily ☐ weekly ☐ monthly

Check yes or no below to indicate if YOU have a history of the following conditions:

Aids/HIV	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Blood/Bleeding Disorders	☐ Yes ☐ No	Cancer _____	☐ Yes ☐ No
Chemical/Drug Dependent	☐ Yes ☐ No	Circulatory Problems	☐ Yes ☐ No	Radiation or Chemo	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Ear Problems	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Eye Problems	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Foot or Leg Cramps	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Hormone Disorder/Thyroid	☐ Yes ☐ No	Implants Prosthetics	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Hepatitis or Jaundice	☐ Yes ☐ No
Phlebitis/Blood Clots	☐ Yes ☐ No	Psychiatric/Mood Issues	☐ Yes ☐ No	Respiratory/Breathing Issues	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Special Diet	☐ Yes ☐ No	Swelling in Ankles or Feet	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Infections	☐ Yes ☐ No	Ulcers _____	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No	Weight Issues	☐ Yes ☐ No		

Please list all current illnesses that you are suffering from: _____

Please list any hospitalizations or surgeries in the last 5 years: _____

Family physician: _____ **Last visit date:** _____

Are you now, or have you been, under any other doctor's care for any other reason over the past 2 years? ☐ Yes ☐ No

If "Yes" please explain: _____

Please list all medications that you are currently taking, include prescriptions, over-the-counter medications and vitamins:

_____

Do you take oral contraceptives or blood thinners? ☐ Yes ☐ No

Please check all items you are currently allergic to:

☐ Adhesive/Tape ☐ Anticoagulant Therapy ☐ Aspirin ☐ Codeine ☐ Demerol ☐ Iodine

☐ Local Anesthetics ☐ Novocain ☐ Penicillin ☐ Seafood ☐ Sulfa

☐ Other: _____ ☐ NO KNOWN DRUG ALLERGIES

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as deemed necessary in the diagnosis and/or treatment. I accept financial responsibility for all charges incurred.

Patient or Legal Guardian Signature: _____ **Date:** _____